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Rapid HIV Testing and Counseling for Residents in Domestic Violence Shelters

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Abstract

Over one million Americans live with the human immunodeficiency virus (HIV), and roughly 20% of those living with HIV are unaware of their status. One way to decrease this epidemic is community-based rapid testing with high-risk populations. One high-risk population that has received limited attention is victims of intimate partner violence (IPV) who seek shelter. In an effort to gain foundational information to implement rapid HIV testing and counseling services in domestic violence shelters, the current study conducted a series of focus groups with 18 residents and 10 staff of local shelters from October 15th to December 12th, 2012. Participants provided valuable insight into how HIV rapid testing and counseling might be best implemented given the resources and constraints of shelter life. Despite identifying some potential barriers, most believed that the promise of quick results, the convenience and support afforded by the shelter venue, and the timing of the intervention at a point when women are making life changes would render the intervention acceptable to residents. Further insights are discussed in the article.

Keywords

HIV/AIDS; partner abuse; screening

Over one million Americans live with human immunodeficiency virus (HIV) with approximately 56,000 becoming newly infected each year. Of those living with HIV, roughly 20% do not know their HIV status (CDC 2011a). To reduce this epidemic, early detection of HIV is critical. Early detection can prevent transmission to others; link HIV positive individuals to medical care and services that can reduce morbidity, mortality, and cost of care; and improve their quality of life. In fact, early initiation of antiretroviral medication has been associated with 96% reduction in HIV transmission to the HIV-uninfected partner, highlighting the importance of early detection and treatment (News 2011).

Community-based rapid testing that provides HIV screening to high-risk populations who face barriers to clinic-based testing can increase early detection. Rapid testing allows for provision of HIV testing, counseling, and test results in one visit, eliminating the need to return for results. Further, rapid testing has been found to be feasible and highly acceptable in multiple community settings (e.g., Rahangdale, Sarnquist, Maldonado, and Cohan 2008; Sena, Hammer, Wilson, Zeveloff, and Gamble 2010). However, although screening has been a cornerstone of the national HIV prevention strategy (CDC 2010), only a 5% increase from 2006 to 2009 has been observed in persons in the United States reporting ever being tested for HIV (CDC 2011b), with 55% of adults having never been tested. Thus, increased testing efforts are needed, particularly among populations at high risk for HIV (CDC 2011a). One such high-risk population that has been underserved in terms of HIV prevention and testing efforts is victims of intimate partner violence (IPV) who seek shelter.

IPV victims face substantial risk for HIV (Campbell, Baty, Ghangour, Stockman, Francisco, and Wagman 2008; Maman, Campbell, Sweat, and Gielen 2000; Sareen, Pagura, and Grant 2009). Ninety percent of HIV transmission among women of childbearing age in the United States has been attributed to heterosexual contact (U.S. Department of Health 2006). Further, one in three women report a history of IPV and approximately 7.0 million women report experiencing rape and/or physical assault by a current or intimate partner every year (Black et al. 2011). Additionally, studies show that IPV victims are more likely than women without IPV to engage in HIV risk behaviors (e.g., Maman et al 2000), especially unprotected sex (El-Bassel, Gilbert, Wu, Go, and Hill 2005). Other factors known to increase the likelihood of HIV infection, such as sexually transmitted infections (STI's) and sex with a high-risk partner, have also been connected to IPV in women (Beadnell, Baker, Morrison, and Knox 2000; Cole, Logan, and Shannon 2006). Victims of IPV face unique HIV/STI risks factors in that they may be unable to negotiate condom use out of fear of retaliation or being raped by their abusive partner (Rountree and Mulraney 2010). Additionally, IPV strongly increases risk for mental health difficulties; particularly posttraumatic stress disorder (PTSD) and substance use disorders (Golding 1999), both of which have been linked to increased HIV-related risk behavior (Campbell et al 2008; Hutton et al 2001; Tubman, Gil, Wagner and Arigues 2003;; Ramsey, Bell, and Engler 2010). Thus, HIV testing and preventative interventions are needed in IPV victims, and these interventions may be more effective if they address the unique HIV risk factors associated with IPV.

In addition to increased risk for HIV, women with IPV underutilize medical care and often encounter barriers to health care, such as transportation difficulties, cost of care, psychological control by their abuser, lack of health insurance, low self-esteem or self-efficacy, and lack of knowledge regarding available resources (Johnson and Zlotnick 2007; Peterson, Moracco, Goldstein, and Clark 2003). Due to this underutilization of healthcare, targeting women while they are in shelter and providing in-house services may be ideal for this population.

Despite the high-risk profile of IPV victims for HIV infection, few HIV risk interventions have been developed or tested that target women with IPV. Of these interventions, specific groups of women have been the study population; low-income Latina women (Davila, Bonilla, Gonzalez-Ramirez, Grinslade, and Villarruel 2008; Theall, Sterk, and Elifson 2004), women released from prison (Weir, B. W., K. O'Brien, R. S. Bard, C. J. Casciato, J. E. Maher, C. W. Dent, ... and M. J. Stark 2009), substance-using women (Weir, Pailman, Mahlalela, Coetzee, Meidany, and Boerma 2003), and adolescents (Wingood et al 2006). Thus, the limited research with this high-risk population demonstrates the importance of future efforts in targeting victims of IPV and their unique risk factors associated with HIV.

Accordingly, given the high risk for STI's and HIV in women with IPV and their barriers to care, domestic violence shelters present an opportune setting for HIV/STI testing and prevention and for reaching a high-risk population not traditionally targeted by HIV/STI programs (Wingood, DiClemente, and Raj 2000). Further, domestic violence shelters, contrary to hospitals or testing clinics, offer a unique setting where no abusers or family members are allowed on premises. Thus, shelters provide confidential, safe, supportive, and resource-rich environments where women can safely obtain test results, cope, and access treatment in cases of positive HIV/STI results.

Utilization of rapid HIV testing has many benefits including limiting testing to a single meeting (Rahangdale et al 2008). Research has demonstrated that shelters lack sufficient HIV/STI policies and programs to appropriately respond to IPV victims heightened risk of infection. Rountree and colleagues (2008) found that fewer than 10% of shelters offer any form of HIV testing. Therefore, although HIV testing and counseling is a crucial resource, research is still needed to explore the feasibility of rapid HIV testing with women residents of domestic violence shelters.

To provide foundational information in anticipation of the development of a rapid HIV testing and counseling intervention to be offered in domestic violence shelters, focus groups were held with multiple residents and staff of local domestic violence shelters. The study aimed to elicit participants' perceptions relative to the following questions: 1) Why do women engage in unprotected sex? 2) How does IPV affect women's sexual experiences? 3) What is the relationship between IPV and unprotected sex? 4) What are the potential barriers to the successful implementation of a rapid testing and counseling intervention in domestic violence shelters? 5) What are the potential facilitators of the successful implementation of a rapid testing and counseling intervention in domestic violence shelters? and 6) What advice do shelter residents and staff have about the implementation of a rapid testing and counseling intervention in domestic violence shelters?

METHODS

Qualitative descriptive methods were used to guide the study (Sandelowski 2000). Qualitative description is used to provide a comprehensive summary of narrative data in everyday terms when a straightforward presentation of findings is desired to inform intervention development and/or implementation. Purposive sampling, the use of focus groups, data collected via a moderately structured interview guide, and low-inference qualitative content analysis were used in this study.

Procedures

Prior to initiating the study, institutional review board (IRB) approval was obtained for the study protocol. Six focus groups were held in domestic violence shelters in two mid-size Midwestern cities. A signed informed consent was received from all participants prior to their involvement in the focus groups. A moderately structured interview guide was developed to query the participants about their thoughts related to the six research questions. The focus groups, which lasted 1–1½ hours, were conducted by a licensed psychologist with expertise in IPV. Four focus groups were held with shelter residents ($n = 18$) and two with staff members ($n = 10$). To recruit shelter residents, research staff attended shelter meetings and described the study to current residents. Interested residents stayed after the meeting to meet with the researcher and complete the Conflict Tactics Scale 2 (CTS2) (Straus, Hamby, Boney-McCoy, and Sugarman 1996) and the Risk Assessment Battery (RAB) (Metzger, Woody, McLellan, et al 1993) to determine eligibility for focus groups. The residents were eligible to participate if the surveys indicated that they had had at least one abusive incident in the three months prior to shelter entry, at least one unsafe sexual occasion with a male partner within the three months prior to residence in shelter, and did not report HIV-positive status. Out of 43 screened participants, 15 (34.88%) did not qualify based on the aforementioned criteria. Of the 15 excluded participants, 14 did not engage in unsafe sexual behavior in the three months prior to shelter, one denied unsafe sexual behavior and any abusive experiences in the three months prior to shelter, and no participants reported positive HIV status. Further, 10 (23.25%) of the participants who qualified for the study did not attend a focus group. To recruit shelter staff, researchers attended staff meetings at the shelters and any staff members who volunteered were included in the focus groups. Any member of the shelter staff was eligible. A total of 15 shelter staff expressed interest in attending focus groups, with ten attending one of the two groups. The dialogue in each group was audiotaped, transcribed, and formatted for analysis.

Data Analysis

One qualitative researcher with expertise in IPV research, two doctoral students in counseling psychology, and a master's student in public health conducted the data analysis of the focus group transcripts. A standard content analysis process (Neuendorf 2002) was used. The team members read all the transcripts in their entirety several times to become familiar with the data. The transcripts were then divided among the team members and relevant sections of text (text units) were coded independently by two team members to six categories reflecting the six research questions. The few coding discrepancies that occurred at this stage were resolved by discussion and consensus. A coding matrix was used to

display the relevant text units. The 28 participants (18 residents and 10 staff members) were represented by the rows on the matrix, and the six categories (research questions) were represented by the columns. The text units in the columns were then compared and contrasted and independently grouped in subcategories by two team members. These team members then met to discuss discrepancies and through consensus revised and labeled the subcategories. The goal was to develop a parsimonious number of subcategories representing factors that answered each question (e.g., barriers and facilitators to intervention implementation). To determine the adequacy of the labels and definitions of subcategories, two team members not involved in their development were given the subcategory labels and definitions and asked to code 100 randomly selected text units to the subcategories. An inter-rater agreement coefficient (number of agreements/number of agreements + number of disagreements) was calculated. The coefficient was .91 indicating that the subcategories were well-delineated and defined. The quality of the findings (Miles, Huberman, & Saldaña, 2014) was therefore enhanced by (1) the use of at least two researchers to code and categorize all data, (2) a discussion and consensus procedure, documented by an audit trail, to resolve discrepancies, and (3) the calculation of an inter-rater reliability coefficient to evaluate the adequacy of the sub-categories that constituted the findings.

FINDINGS

No significant differences in age or race were found between those shelter residents who met study criteria and participated in focus groups and those who did not participate. Eleven of the resident participants were White; four were African American; two were Biracial, and one was American Indian/Alaska Native. One participant identified as Hispanic. Age of residents ranged from 18 to 55 years ($M = 35.8$ years, $SD = 10.40$ years). Eight of the shelter staff participants were White, and two were African American. Most participants contributed actively to the discussions in the focus groups, although a few members in each of the resident groups were reticent. Though the residents and staff agreed on most issues, as did participants from the two shelters, it is noted below when the responses of these groups differed in a significant way.

Why women engage in unprotected sex

The participants identified seven reasons why women in general engage in unprotected sex. Most of the responses to this question were provided by the shelter residents. In several cases, the residents provided reasons why they had engaged in unprotected sex themselves.

Condoms cause physical discomfort—Several residents indicated that women engage in unprotected sex because condoms are uncomfortable for both men and women. Some said that condoms are painful, irritating or fit poorly, and others said they decrease pleasure. One shelter resident said, “I did that [had unprotected sex] cuz it [the condom] hurt... I’m like, ‘Just take it off.’ It was the moment. It hurts, it chafes. Even when you use a lubricant, you still have problems...” Most of the shelter residents were either unfamiliar with female condoms or scoffed at their use, claiming they slip, are poor fitting, or “corny.”

Practical hurdles to obtaining protection—Other participants indicated that women may engage in unprotected sex because it is a “hassle” to obtain protection, noting that condoms can be costly or hard to obtain. They mentioned the high price of condoms, the problem of getting transportation to obtain them, and the fact that health insurance plans do not cover the purchase of condoms. One resident said, “You go to a corner store, you’re paying a dollar for one condom, you’re paying 14 or 15 dollars for a box of condoms.”

Being uninformed about HIV risks—Lack of awareness of HIV risks was another factor cited by the participants as contributing to incidents of unprotected sex. One of the resident groups, for example, had a conversation about how wealthy women are at risk for HIV without knowing it because they make naïve assumptions that their husbands would not cheat on them. The other resident group discussed how being brought up in a small town or a rural community can put one at risk for HIV because people in these areas do not talk about sexual matters or discuss them with their healthcare providers. One resident said, “How many people in a town of 150 people are talking about HIV and AIDS? They don’t talk about that in the doctor’s office.... The same doctor you had is the doctor your great grandmother had.” One resident indicated that African American women are at high risk for HIV because their communities tend to provide little education about STDs, and another resident suggested that older women are at high risk because they are less knowledgeable about the disease.

Using drugs and alcohol—Several participants indicated that substance use plays a role in unprotected sex. A few residents acknowledged that they themselves had had unprotected sex when intoxicated or high. The participants suggested that unprotected sex occurs when women are “blacked out” or “don’t care” because they are intoxicated. One staff member suggested that women may engage in unprotected sex to procure drugs.

Sex occurs spontaneously—Other residents suggested that women engage in unprotected sex because sex occurs spontaneously even when substances are not involved, and they do not think about protection until “it [sex] is over.” One resident mentioned that some women might not think about protection in the “heat of the moment,” whereas another suggested that some women might enjoy the “thrill of the risk.”

Assuming a committed relationship with sex partner—Several participants indicated that women do not use protection because they assume they and their partner have an exclusive relationship and therefore protection is unnecessary. One resident said that she had unprotected sex with her partner because she trusted him: “Because I wanted to believe I was the only one.... We were supposed to get married, found out he was still married, and seeing one of my friends.” Several residents stressed that it is particularly difficult to ask a partner to use condoms if the couple had already had sex without one.

Protection implies cheating or infection—A common response by participants was that women do not use protection because asking a partner to use a condom implies that she is cheating or already infected or that she believes her partner is cheating or infected. For example, one shelter resident said, “So I took risks [unprotected sex] I knew I shouldn’t take even though I was married to the man. Because I felt pressured, I wanted to show him that I

wasn't cheating." Foregoing a condom, therefore, can be regarded as proof of the woman's fidelity or an endorsement of her belief in her partner's fidelity.

The effects of IPV on sexual experiences

The resident groups initially discounted the idea that IPV influences women's sexual experiences. Several stressed that their own relationships were physically, but not sexually, abusive, and that they enjoyed sex with their partners. However, as the interviews progressed, they identified two ways in which IPV might influence women's sexual experiences.

Distancing self—A few residents suggested that if women in abusive relationships do not desire sex, they tolerate it by distancing themselves during intercourse, pretending to enjoy sex when they do not, or shutting down emotionally rather than refusing to have sex with their partners. The residents indicated that women who are abused often "close their eyes and pretend," "just lie there," shut down like a "blow up doll" or a "dead fish," review their "do-to list," "zone out," or "drift away."

Sex as a distraction from abuse—According to some residents, women in abusive relationships sometimes use sex to divert a partner from abuse. One resident explained, "You're just worried about getting away from him.... You probably worry about getting them [abusive partners] to sleep.... I would personally try to get [him] to sleep by [getting him] to do me." Others described using sex to make up after a fight or feel normal after a violent episode.

The relationship between IPV and unprotected sex

The residents also initially suggested no connections between IPV and unprotected sex. As the interviews progressed, however, they identified some ways in which abuse can lead to unsafe sexual practices.

Diminished self-esteem or self-efficacy—Several residents argued that IPV lowers women's self-esteem and renders them non-assertive or acquiescent and thus at risk for unprotected sex. Some suggested that abused women may not feel safe asking their partners to use protection and some "give in" when partners demand sex without protection because the women fear retaliation if they refuse. One resident suggested that abused women do not "bother" to use protection because they do not see themselves as worthy of it.

Being compelled by partner to have unprotected sex—Some participants pointed out that abusive men force, intimidate, manipulate, or use emotional or financial control to pressure women into having sex without protection. Several mentioned that abusive men also tend to convince women to have sex without protection by pledging love and fidelity. One resident indicated that her partner refused to give her money to buy condoms.

Barriers to implementation of the intervention

Both the residents and staff provided much information about what they perceived as potential barriers to the successful implementation of the intervention in the shelters. Some

of the barriers were related to the environment of the shelter and some were related to the characteristics or situations of the women.

Lack of confidentiality and privacy in the shelters—Both staff and residents were particularly concerned that residents might not accept the intervention because they would fear that other residents and staff would find out that they were getting tested and then gossip or start rumors. Many of the residents suggested that gossip was common in the “close-knit” shelter environment, and it would be embarrassing to have others know one needed to be tested or had tested positive. A fear that others “would know your business,” therefore, was viewed as a major deterrent to the acceptability of the intervention. One resident compared the shelter environment to high school: “I think women might shy away. Who’s gonna see me going in there? Who is going to be questioning you or starting rumors?” One resident group in particular was concerned that staff members would break confidentiality and spread rumors about the women getting tested. Several residents said they would be particularly concerned about confidentiality if a woman tested positive. One resident suggested that even if a woman tested negative, others would assume she was positive and “drama” would ensue. Another asserted that it would be “messed up” to have others around if a resident found out she was infected.

The inconvenience of the intervention—A couple of participants indicated that women might not accept the intervention because it would be a “hassle.” Several mentioned that women would have to worry about having someone watch their children during the intervention. Others said some residents would not have the time to participate if they were working while in the shelter or burdened with other matters.

Fear of the results—Many participants indicated that women might resist the intervention because they would dread receiving “bad news.” Several indicated that some women would not want to know if they were infected because they would then have to face the demands of the disease, which could seem to be insurmountable. These demands would include obtaining treatment, paying for the high costs of medication, or arranging transportation to get care.

Personal characteristics of the women—Some participants indicated that women in the shelters might have personal characteristics or traits that would serve as barriers to their taking part in the intervention. Some staff members indicated that women in the shelters might not participate in an intervention due to low self-esteem, lack of motivation, resistance to learning new things, or fear of making life changes. A few residents suggested that women might not “love themselves” enough to get tested.

The shame of HIV—Several participants indicated that women might not accept the intervention because of the shame associated with HIV. They indicated that women would be reluctant to get tested because if they were infected, they would blame themselves for the disease, experience “societal shame,” or feel “diseased.”

Other testing options—One resident indicated that she would want to be tested by her own doctor rather than a “stranger” in the shelter. Another indicated that she would not participate in the intervention because she had been recently tested.

Facilitators of implementation of the intervention

Although the groups identified a number of potential barriers to the intervention, both residents and staff generally felt positive about the possibility of offering the intervention in shelters. They identified several factors that would enable the intervention’s success.

Short wait time for results—Both residents and staff stated that getting the results in the same session as the testing would be appealing to women in shelters. Several participants mentioned that in the past people had to wait several weeks to get the results, and the wait was very “nerve-wracking.” One resident said, “You’re gonna wanna get the [results] as quick as possible. You’re not gonna wait more than you have to.”

Convenience—Several participants indicated that the intervention would be acceptable to residents because it would be convenient. Because the interveners would be “coming to you,” the residents would not have to worry about setting up and traveling to an appointment. One resident said, “I set up doctor appointments all the time and two weeks later ... I’m like, I’m not going cause I either forgot or I got something else to do or I’m not feeling like it.”

Available support at shelter—A few residents and staff mentioned that the shelters were good venues to offer the intervention because the residents would receive emotional support that might not be available otherwise. The participants indicated that women would especially welcome the availability of counseling immediately after receiving results. Several residents mentioned that the shelter staff would also “be there” to help them, and residents would have each other to rely on if they got “bad news.”

Avoid lack of privacy of other venues—Though lack of confidentiality and privacy at the shelters was commonly mentioned as a potential barrier to the intervention, conversely, a few residents and staff members mentioned that some women would welcome the intervention being delivered in the shelters because they were more private than some other testing venues. Several feared they would be “talked about” if they were tested at the public health department.

Good time in their lives—Several residents and staff suggested that offering the intervention in the shelter would be well-timed. The participants reasoned that women are in the shelter because they are “getting their lives together” and would therefore want to “clear the air” about their HIV status. Some indicated that because many residents are dealing with empowerment, being tested for HIV would further enable them to take control of their lives.

Advice about offering the intervention in shelters

Participants provided practical advice about how to implement the intervention in domestic violence shelters. The advice was often related to barriers and facilitators they had identified and much of the advice was aimed at protecting confidentiality and privacy.

How to inform the women about the intervention—The participants provided recommendations about how shelter residents should be informed about the availability of the intervention. Some suggested informing residents about the testing at “intake” or during a routine or mandatory meeting. In this way, it would be part of the normal routine of the shelter and therefore seem like “no big deal.” One staff member recommended that the interveners come to a house meeting to talk about AIDS generally as a way of introducing the intervention. Although some participants suggested placing fliers around the shelters to alert women to the intervention, one resident indicated that women often do not read such fliers.

How to schedule appointments for the intervention—Some disagreement was noted about how appointments for the intervention should be scheduled. Staff from both shelters suggested appointments be scheduled through case managers, although some staff members from one shelter disagreed about whether the case managers or the house staff who interact with the women on a daily basis would be the best personnel to do this. Yet other staff members thought that the women should be given a phone number to schedule their own appointments if they wished to participate because this procedure would be the most empowering.

Where to offer the intervention—Participants weighed in on where the intervention should be offered. Some believed it should be offered on-site at the shelters to avoid “community shame,” whereas some thought it should be offered off-site because of the lack of privacy at the shelter. Yet other participants suggested that the women be given the choice of venue (on- or offsite). One group disagreed about whether the intervention should be offered in the shelter or at a community services site run by the shelter program.

How to deliver the intervention—Participants had a variety of ideas about the optimal delivery mode, timing, and duration of the intervention. A few participants recommended that the intervention should be embedded in a “health fair” to avoid stigma. The intervention would then be viewed as customary health teaching, such as is done regarding breast health or hypertension, and residents would find it less threatening.

The participants disagreed about when the intervention should be offered. Some suggested it should be scheduled at night because women are often out of the shelter during the day, whereas others suggested it should be scheduled during the day when it is less hectic and children are at school. The participants stressed that if the intervention were offered in the evening, childcare should be provided. Participants from both shelters suggested avoiding weekends because residents view weekends as their “down time,” sleep in late, or are away from the shelters. The participants agreed that an hour would be an adequate time for the intervention.

Most participants believed residents should get the results of the testing before the counseling so they could concentrate on the counseling rather than worrying about their test results while with the counselor. They strongly believed that the counseling component should include practical recommendations about how the women could obtain effective and affordable treatment if they tested positive. Other topics they suggested should be included in the counseling were facts about the disease in general (including ways it is transmitted), a demonstration of the use of female condoms, and ways to boost self-esteem and decrease shame.

Characteristics of the intervener—The residents in particular voiced opinions about what characteristics were needed in an intervener for the intervention to be successful. Although most denied that the race was important, they agreed that the intervener should be a woman. The residents stressed that it is most important that the intervener not appear to be “scared” to be in the shelter and should be caring and understanding.

Need for staff training—Several staff members believed that shelter staff who host the intervention need to have training about HIV. They indicated that the training should address disease transmission, how to best support residents, how to avoid stigma and stereotyping, how to dispel myths about HIV, and how to handle “blood incidents” in the shelters.

DISCUSSION

Despite identifying some potential barriers, the participants were for the most part enthusiastic about the possibility of a rapid HIV testing and counseling intervention being offered in domestic violence shelters. Consistent with prior research regarding the feasibility and acceptability of rapid testing and counseling in community settings (Rahangdale, Sarnquist, Maldonado, and Cohan 2008; Sena, Hammer, Wilson, Zeveloff, and Gamble 2010), most participants believed that the promise of quick results, the convenience and support afforded by the shelter venue, and the timing of the intervention at a point when women are making life changes would render the intervention acceptable to residents. Although women who seek shelter in response to IPV are often survival-focused and therefore can be emotionally vulnerable, shelter residents in this study overwhelmingly agreed that domestic violence shelters provide a safe and supportive environment for HIV testing. Shelter residents highlighted that shelter is a time when women are focused on “getting their lives together,” and suggested that a rapid HIV testing and counseling intervention at this time could be empowering for many women. However, we recognize that all shelter residents may not be emotionally ready to handle the stress of HIV testing and the possibility of a positive result. Any shelter-based HIV testing and counseling intervention should include a discussion of a woman’s preparedness for the possibility of a positive test result and empower women to choose to defer such testing to a time when they are more emotionally prepared if needed. Additionally, given the vulnerability of this population, counselors providing testing services, as well as shelter staff need to be sufficiently trained to provide the necessary support and referrals for psychological support in the event of a positive result.

The participants provided much information that would assist healthcare and shelter professionals in developing and implementing rapid HIV testing and counseling interventions. In addition to healthcare barriers identified in previous research (e.g., transportation difficulties, cost of care, lack of health insurance; Johnson and Zlotnick 2007; Peterson, Moracco, Goldstein, and Clark 2003) several unique obstacles were identified. For example, although some of the barriers identified by the participants were related to a general fear or reluctance that one would test positive and the shame associated with the disease, the greatest concern expressed by the participants was that others would know the women's "business" and gossip. Therefore, for the intervention to be successful, each shelter would need to determine how to best protect the confidentiality and privacy of the women who receive it. It is important to note that both shelter residents and staff indicated a number of sufficient strategies to assure that the testing could be delivered in a confidential manner.

Although some disagreement was noted about the logistics of offering the intervention in shelters, general consensus was that if the intervention could be announced within the established routines of the shelter (e.g., intakes, house meetings) and embedded in other programming (e.g., health education offerings), the stigma of participation might be reduced. The participants also suggested that residents would feel most empowered if they were given a choice of the site of the intervention (e.g., shelter, off-site location) and were allowed to schedule their own appointments. This finding is consistent with empowerment theory citing the importance of creating the opportunity for choice in disempowered populations (Zimmerman 2000). Further, consistent with Sullivan and Cain's 2004 recommendations when working with IPV victims, the participants stressed that the interventionists should be comfortable in the shelter environment, suggesting that providing them with education about IPV issues and experience with IPV populations would increase the acceptability of the intervention for shelter residents. Finally, providing childcare so the residents would be free to participate as well as staff training related to HIV were deemed critical for successful implementation.

The information provided by the focus groups will also aid in the tailoring of the intervention for women who experience IPV. Consistent with prior research demonstrating the importance of educating survivors on the relationship between IPV and risk for HIV and other sexually transmitted infections (Phillips, Walsh, Bullion, Reid, Bacon, and Okoro 2013), shelter residents felt that highlighting the intersection between IPV and HIV was an important element of the intervention's counseling component. Although participants identified a myriad of reasons that women engage in unprotected sex, such as problems with condoms, lack of education, and substance use, the relationship dynamics related to requests for protection were particularly important and would need to be discussed. Specifically, participants reported the risks associated with condom use noting that their partners may assume infidelity or the existence of a sexually transmitted infection. As a result, issues of safety in the context of negotiating protection, unprotected sex as a way of managing violence, and the role of self-esteem in requesting protection are also important issues (Phillips et al 2013). Empowering women to take control of their sexual health through the use of female condoms, and educating women about some of the benefits of the female condom (e.g., increased pleasure in both men and women) may also provide women with an

alternative strategy for protecting themselves without jeopardizing their physical or emotional safety.

The present findings also supported multiple changes to standard practice when working with survivors of IPV. First, although we did not ask about the acceptability of STI testing in shelters, given the identified relationship between IPV and risky sexual behavior (e.g., Maman et al 2000), testing for additional STIs, including gonorrhea, chlamydia, trichomoniasis, and syphilis, during shelter stay may also be warranted. Furthermore, findings suggested that providing education and referrals to women for HIV/STI testing should become universal for domestic violence shelters, counseling services, medical providers or other agencies working with women who have experienced IPV. Finally, our culture needs to move away from the assumption that safe sex is always an option, as many survivors provided evidence that asking their partner to use a condom might result in further violence. Thus, shame and punishment of survivors should be avoided and replaced with validation and understanding of their risk within the unique context of intimate partner violence.

Although this study added to the current literature regarding HIV intervention for survivors of IPV, it is important to identify several of the study's limitations. First, we had limited descriptive information on a relatively small number of IPV victim participants, including how long each had been in the shelter. Further, all participants were recruited from domestic violence shelters in a small geographical region in the mid-west. Therefore, the sample may not be representative of women who have suffered IPV, and thus the generalizability of the findings is limited. Furthermore, all IPV victim participants were currently in a shelter, which includes only a small subset of women currently experiencing IPV. Additionally, 10 participants who met study criteria did not attend the focus groups. These women may have intentionally not attended because of negative attitudes toward HIV testing and counseling. Therefore, the findings might not apply to such women who might be especially vulnerable to acquiring or transmitting HIV. Future research should be conducted with larger groups of women from various geographical, racial, and residential settings. Finally, research is still needed to determine if some IPV victims may be more open to HIV testing and counseling services than others and what factors may influence women's openness to testing while in shelter.

In closing, the participants in this study provided insight into the feasibility and implementation of an intervention including rapid HIV testing and counseling. Despite barriers such as a general fear of testing positive and confidentiality concerns, the overall consensus of the groups were positive. Skilled interventionists and flexibility in choices regarding the testing location were deemed crucial in putting into effect such an intervention. Further, a focus on the intersection of IPV and HIV during the counseling session in addition to empowering women to take control of their sexual health could prove essential in reducing behaviors associated with risk of HIV. In sum, rapid HIV testing and counseling appears to be a plausible option for IPV victims currently residing in shelter and future research in this area is warranted.

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